TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH DBA INJURY 1 DALLAS

Respondent Name
CHUBB INDEMNITY INSURANCE CO

MFDR Tracking Number
M4-17-0560-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
October 31, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The services were provide and the claims were denied per EOB based on entitlement to benefits... The treatment that was provided is part of his compensable injury..."

Amount in Dispute: $2,398.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...the individual psychotherapy sessions in dispute were not paid in this matter due to an extent of injury dispute... Requestor skewed their billing in an attempt to get paid for services provided to treat non-compensable conditions. Payment for these services should not be owed."

Response Submitted by: Downs Stanford PC

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
April 22, 2015 through November 5, 2015	90791, 90837 x 4, 96151 and 96101	$2,398.57	$381.48

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets out the procedure for Medical Fee Dispute Resolution.
3. 28 Texas Administrative Code §141.1 sets out the procedures for Requesting and Setting a Benefit Review Conference.
4. 28 Administrative Code § 133.240 sets out the medical bill processing/audit by an insurance carrier for medical payments and denials.
5. Former Texas Labor Code §408.027 sets out the payment of health care provider.
6. 28 Texas Administrative Code §134.204 sets out the sets out the Medical Fee Guideline for Workers' Compensation Specific Services.
7. 28 Texas Administrative Code §134.203 sets out the sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.

8. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P6-Based on entitlement to benefits
   - 219-Based on extent of injury
   - P12 – Workers' Compensation state fee schedule adjustment

Issue(s)

1. Does the medical fee dispute referenced above contain information/documentation to support that the disputed services rendered on April 22, 2015 contains an unresolved relatedness issue?
2. Did the requestor waive the right to medical fee dispute resolution for dates of service June 19, 2015 through July 7, 2015?
3. Does the insurance carrier's position statement address only those denial reasons presented to the requestor for date of service November 5, 2015?
4. Is the requestor entitled to reimbursement for CPT Code 96101 rendered on November 5, 2015?

Findings

1. The insurance carrier denied CPT Code(s) 90791 rendered on April 22, 2015 with denial reason(s) code "P6-Based on entitlement to benefits."

   Review of the submitted documentation finds that the medical fee dispute referenced above contains information/ documentation to support that there are **unresolved** issues of relatedness/extent of injury for date of service April 22, 2015. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical bill review process.

   28 Texas Administrative Code §133.305(b) requires that a relatedness/extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f) (3) (C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved relatedness/ extent-of-injury issue. The Division finds that the dispute contains an unresolved relatedness/extent-of-injury issue for the dates of service indicated above. As a result, the dates of service identified above are not eligible for review by MFDR until final adjudication of the relatedness/extent-of-injury issue.

   The Division hereby notifies the requestor that the appropriate process to resolve the relatedness/extent-of-injury issue may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1.

   28 Texas Administrative Code §133.307(f) (3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.

2. The requestor seeks reimbursement for dates of the service June 19, 2015 through July 7, 2015. 28 Texas Administrative Code §133.307(c)(1) states:

   > Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
   >
   > (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   The dates of the service in dispute are June 19, 2015 through July 7, 2015. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on October 31, 2016. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed dates of the service, June 19, 2015 through July 7, 2015 do not involve issues identified in §133.307(c)(1)(B). The insurance carrier denied these dates with denial reason codes that are not identified in§133.307(c) (1) (B). As a result, the requestor was required to file these dates of service within the one year filing deadline. The Division concludes that the requestor has failed to timely file these dates of service with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for dates of the service June 19, 2015 through July 7, 2015.

3. The requestor seeks reimbursement for CPT Code 96101 rendered on November 5, 2015. The insurance carrier's position statement asserts that "the individual psychotherapy sessions in dispute were not paid in this matter due to an extent of injury dispute." Review of the EOB presented by the requestor finds the following:

   EOB dated December 22, 2015, contains the following denial reason code(s):

   - P12 – Workers' Compensation state fee schedule adjustment

   To determine whether such an extent-of-injury or relatedness dispute existed at the time any particular medical fee dispute was filed with the Division and whether it was related to the same service, the applicable former version of 28 Texas Administrative Code § 133.240 (e) (1), (2) (C), and (g) addressed actions that the insurance carrier was required to take, during the medical bill review process, when the insurance carrier determined that the medical service(s) was/were not related to the compensable injury:

   Per 31 TexReg 3544, 3558 (April 28, 2006), those provisions, in pertinent part specified: Former 133.240 (e) (1), (2) (C), and (g): The insurance carrier shall send the explanation of benefits in the form and manner prescribed by the Division.... The explanation of benefits shall be sent to: (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and (2) the injured employee when payment is denied because the health care was: ... (C) unrelated to the compensable injury, in accordance with § 124.2 of this title... (g) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code § 409.021, and § 124.2 and 124.3 of this title ... if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that:. . (3) the condition for which the health care was provided was not related to the compensable injury.

   Former Texas Labor Code §408.027(d) [currently 408.027(e)], Acts 1993, 73rd Legislature, Chapter 269, effective September 1, 1993, requires that "If an insurance carrier disputes the amount of payment or the health care provider's entitlement to payment, the insurance carrier shall send to the commission [now the Division], the health care provider, and the injured employee a report that sufficiently explains the reasons for the reduction or denial of payment for health care services provided to the employee."

   No documentation was found to support that the insurance carrier sent the required report containing sufficient explanation of the above reason(s) for the reduction or denial of payment. The EOB indicates denial reason code P12 "Workers Compensation state fee schedule adjustment." The EOB reflects allowed fee of $381.51, however no check number and/or information to support that a check was issued in the amount of $381.51. The requestor indicates on the Table of Disputed Services that $0.00 payment was received for this date of service. The Division concludes that the insurance carrier has not met the requirements of 408.027 and §133.240. This new defenses are therefore not supported for CPT Code 96101 rendered on November 5, 2015**.** The disputed service is therefore reviewed per applicable Division rules and fee guidelines.

4. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

   Procedure code 96101, rendered on November 5, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.86 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 1.89348. The practice expense (PE) RVU of 0.32 multiplied by the PE GPCI of 1.009 is 0.32288. The malpractice RVU of 0.06 multiplied by the malpractice GPCI of 0.772 is 0.04632. The sum of 2.26268 is multiplied by the Division conversion factor of $56.20 for a MAR of $127.16 at 3 units is $381.48.

   Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of $381.48. Therefore, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $381.48.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $381.48 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		December 2, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.